

**Medicaid TBI WAIVER PROGRAM
Quality Improvement Advisory (QIA) Council Evaluation**

Participant Name: _____ Provider: _____
(Optional) (Optional)

Meeting Date: _____ Quarter: _____

At APS-WV, we are continually working to improve the quality of our work. Therefore, it is very important to receive your feedback. Please take a few minutes to complete this evaluation. Your responses will help us understand your needs and identify opportunities for improving future TBI Waiver QIA Council Meetings. Thank you.

A	<p>Please check <u>one</u> of the following that best describes your role on the Council:</p> <p> <input type="checkbox"/> Member <input type="checkbox"/> Legal Representative of Member <input type="checkbox"/> Provider </p> <p> <input type="checkbox"/> Advocate <input type="checkbox"/> State agency/contractor <input type="checkbox"/> Other: _____ </p>
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B	<p>Please examine the following responses and circle <u>one number</u> For each Evaluation Item that best describes your opinion.</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>1 – I strongly disagree with this statement.</p> <p>2 – I disagree with this statement.</p> <p>3 – I am not sure if I agree or disagree.</p> </div> <div style="width: 45%;"> <p>4 – I agree with this statement.</p> <p>5 – I strongly agree with this statement.</p> <p>6 – This statement does not apply to me.</p> </div> </div>
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Evaluation Items	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Applicable
1. I feel this quarterly meeting was productive.	1	2	3	4	5	6
2. I feel that as a Council member my input is valued.	1	2	3	4	5	6
3. I feel the amount of time spent for this meeting was adequate.	1	2	3	4	5	6
4. The materials presented were useful and easy to understand.	1	2	3	4	5	6
5. The meeting location was convenient and accessible.	1	2	3	4	5	6
6. Overall, I am satisfied with this quarter's meeting.	1	2	3	4	5	6

C	<p>Comments or suggestions for the next Medicaid TBI Waiver QIA Council meeting</p> <hr/> <hr/> <hr/>
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